

AGY /SUB AGY	
EFF. DATE	MO/DAY/YR
Current Agency Hire Date MO/DAY/YR	

State of Washington
Benefits Contribution Plan
Section 125 Waiver Form

- Type or print clearly in ink.
- Shaded areas are for agency use only.
- Check all copies.

SECTION 1: Subscriber Information					
Personnel Number	Last Name	First Name	Middle Initial	Is This a Name Change? <input type="checkbox"/> Yes <input type="checkbox"/> No	Agency/Division Name
Home Mailing Address					
City			State	ZIP Code	
County (residence)	Home Phone Number ()	Work Phone Number ()		Date of Birth MO/DAY/YR	
SECTION 2: Waiver of Insurance					
I elect to waive the opportunity to participate in the state of Washington sponsored Benefits Contribution Plan authorized under Section 125 of the IRS code, or Section 125 Plan. I understand that by waiving participation in the Benefits Contribution Plan any premium I may be required to pay for the medical coverage I have selected will be deducted from my paycheck after all federal and/or state taxes have been collected.					
Employee's Signature				Date	